Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED						
			A. BUILDING: _									
005016		B. WING		03/06/2015								
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE												
LUTHERAN HOSPITAL OF INDIANA FORT WAYNE, IN 46804												
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE						
S 000	INITIAL COMMENTS		S 000									
	The survey was for in hospital complaint. Complaint Number: In Substantiated: Deficiallegations.											
	Date: 3-5/6-15											
	Facility Number: 005	016										
	Surveyor: Brian Mon Public Health Nurse S											
	QA: claughlin 03/26/	15										
S 838	S 838 410 IAC 15-1.5-5 MEDICAL STAFF		S 838			4/8/15						
	410 IAC 15-1.5-5 (b)(1)											
	(b) The medical staff and enforce bylaws and ruits responsibilities. The rules shall:	ules to carry out										
	(1) be approved by th board;	e governing										
	medical staff failed to bylaws, rules and reg patient records contai	t as evidenced by: nt review and interview, the enforce its medical staff ulations and assure that all ined a discharge summary ords (MR) reviewed (patient										

Indiana State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED							
			A. BOILDING.									
005016			B. WING		03/06/2015							
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE												
LUTHERAN HOSPITAL OF INDIANA 7950 W JEFFERSON BLVD FORT WAYNE, IN 46804												
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETE DATE						
S 838	Continued From page 1		S 838									
	Findings:											
	1. The Medical Staff (approved 6-13) indic "Attending Physician's Inpatient medical recording the following (16) A 2. The MR for patient indicated an order was 4-13-12 at 1900 hours the attending physicial a discharge summary the episode of care. 3. During an interview the health information confirmed that no disc	s Responsibilities4.2B ords shall include at least A discharge summary" It 27's 3-20-12 admission as written by MD14 on as assuming responsibility as an and no documentation of a was identified in the MR for a won 3-5-15 at 1450 hours, a management director A5										

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